

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-004749

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 14

FILED FEB 4 1963

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| 1. PLACE OF DEATH a. COUNTY <u>Saline</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>mo.</u> b. COUNTY <u>Saline</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marshall</u> | Length of stay in 1b <u>12 da</u> | c. CITY OR TOWN <u>Marshall</u> | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Fitzgibbon Hosp.</u> | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>R 2</u> | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>IRVIN</u> Middle <u>NATHANIAL</u> Last <u>BLACKERBY</u> | | 4. DATE OF DEATH Month <u>Jan.</u> Day <u>27</u> Year <u>1963</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-27-1886</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u> | 11. BIRTHPLACE (City and state or country) <u>Ray County, Mo</u> |
| 13a. FATHER'S NAME <u>Samuel Blackerby</u> | | 13b. MOTHER'S MAIDEN NAME <u>Elyzabeth Mullin</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>332X</u> | | 16. SOCIAL SECURITY NO. <u>61</u> | |
| 17. INFORMANT <u>Mr. J. N. Blackerby</u> | | Address <u>Marshall Mo R 2</u> | |

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| 18. CAUSE OF DEATH (Enter only one cause of death) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis Generalized</u> | | |
| DUE TO (c) _____ | | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease, condition given in PART I (a) <u>Prolonged illness, Bronchopneumonia, Diabetic Mellitus</u> | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) |
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____ | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____ |

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| 21. I attended the deceased from <u>April 1960</u> to <u>Jan. 1963</u> and last saw her alive on <u>27 Jan. 1963</u> Death occurred at: <u>7:00 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE (Degree or title) <u>Dr. W. O. ...</u> | 22b. ADDRESS <u>Marshall, Mo.</u> | 22c. DATE SIGNED <u>1-29-63</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>1-29-1963</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Garden</u> | 23d. LOCATION (City, town, or county) <u>Marshall</u> | (State) <u>mo</u> |
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| 24. FUNERAL DIRECTOR <u>Harry Zerschinger</u> | ADDRESS <u>Marshall, Mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>1-28-63</u> | 26. REGISTRAR'S SIGNATURE <u>Cecil A. Read</u> |
|--|---------------------------------|--|---|

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBONVS 300
Rev. 4/59

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Harry Hershberger

Licensed Embalmer No. 4357

P. O. Address Marshall, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.